1. PURPOSE:

1.1. The Quality Improvement Program monitors the availability, accessibility, continuity and quality of care and services on an ongoing basis.
1.2. To monitor the quality of care and services provided by participating providers, practitioners, and independently contracted delegates.
1.3. To Maintain a systematic approach to monitor, evaluate, improve and ensure provider and member access to utilization management services.
1.4. Maximize safety and quality of health care delivered to members through the continuous quality improvement process.
1.5. Maintain a high level of satisfaction in members, providers and customers on the services provided by Horizon.
1.6. Maintain compliance with MOH regulatory requirements and CBAHI accreditation standards

2. DEFINITION(S):

2.1. QUALITY IMPROVEMENT (QI)- is a systematic, formal approach to the analysis of practice performance and efforts to improve performance.
2.2. IMPROVING PERFORMANCE - is continuous study and adaptation of processes in order to achieve desired outcomes and meet the needs and expectations of members, clients and stakeholders.
2.3. QUALITY AND PATIENT SAFETY PLAN: describes the multidisciplinary, systematic performance improvement framework developed by General Hospital to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission of the hospital.
2.4. QUALITY TOOLS – tools that are used in problem identification, data collection and analysis implementation and evaluation.
2.5. CUSTOMERS - organization or person that receives a product or services.
2.6. HEALTH CARE ENVIRONMENT – the structures and processes employed to provide care. Reflects the characteristics of the facility (e.g. size, location, specialty, licensure, certification, equipment); and the organization (e.g. personnel mix and experience, lines of authority, policies and procedures, governance, leadership, culture)
2.7. STRUCTURE – evidence of an organization's ability to provide care to clients (e.g. Equipment, staff number and qualifications, work space, resources).
2.8. PROCESS – refers to the procedures, methods, means or sequence of steps for providing or delivering care and producing outcomes.
2.9. OUTCOME – refers to the results of care, adverse or beneficial.
2.10. DATA – raw facts or figures.
2.11. INDICATOR - a measure used to determine, over time, the performance of functions, process and outcomes of an organization.
2.12. ACCREDITATION – a voluntary survey process used by various independent, non-governmental external agencies to assess the extent of

healthcare organization's compliance with applicable pre-established performance standards set by the agency. It involves both self- assessment and external peer review, focusing on organizational, not individual practitioner, performance.

2.13. STANDARDS – a statement that defines the performance expectations, structures, or process that must be in place in an organization to provide safe and high-quality care, treatment and services.

2.14. PATIENT SAFETY- actions undertaken by individuals and organization to protect health care recipients from being harmed by the effects of health care services.

2.15. RISK MANAGEMENT- monitoring, evaluation and follow-up of potential or actual circumstances or events that poses a threat to patient or staff safety and/or visitor safety, delivery of care/ services, or loss/damage to property.

2.16. ADVERSE EVENT – an untoward and usually unanticipated outcome that occurs in association with health care

2.17. ADVERSE OUTCOME ERRORS – those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified physical or psychological adverse outcome for the patient.

2.18. HARM – death or impairment of a body function or structure requiring intervention.

2.19. HAZARD – a setting or technology that has the potential to cause harm.

2.20. HEALTH CARE ASSOCIATED INJURY – harm caused to the patient through medical error and not as a result of the natural course of a patient's condition.

2.21. MEDICATION ERROR- is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products and systems, including: prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

2.22. MEDICAL ERRORS – mistakes made in the process of care that result in or have the potential to result in harm to patients. It includes the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. It can be the result of an action that is taken (error of commission) or an action that is not taken (error of omission).

2.23. PREVENTABLE INJURY – harm that could be avoided through reasonable planning or proper execution of an action.

2.24. SENTINEL EVENT – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specially includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance

of serious adverse outcome. Such events are called "sentinel "because they signal the need for immediate investigation and response.

2.25. NEAR MISS – an error which does not reach the patient or cause harm.

2.26. HAZARDOUS CONDITION – any set of circumstances, exclusive of the disease or condition for Which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

3. RESPONSIBILITY:

3.1. Hospital Board

3.1.1. Ultimately responsible for assuring that high quality care is provided for all patients, visitors and staffs.

3.1.2. Support and guide quality improvement activities in quarterly meetings and also reviewing, evaluating and approving the Quality Improvement Plan annually.

3.1.3. Delegate the responsibility for implementing the Quality Improvement Plan to the Supervisor General who will in turn use his authority through the Quality Improvement Committee to achieve the goals and objectives.

3.2. Hospital Director

3.2.1. Oversee Quality Improvement Committee activities.

3.2.2. Oversee Accreditation Steering Committee activities.

3.2.3. Approve Quality Improvement Plan including:

3.2.3.1. Quality Improvement Strategic Goals and Objectives

3.2.3.2. List of Hospital wide Indicators

3.2.3.3. Performance Improvement Projects & Initiatives

3.2.3.4. Quality Improvement Education and Training

3.2.4. Provide the needed resources to support the proper functioning of Quality Improvement activities.

3.2.5. Ensure that medical, nursing & other department heads are involved in the implementation of the Quality Improvement Plan.

3.2.6. Create, review and approve policies and procedures necessary to carry out the mission of the Hospital. Supervisor General shall work collaboratively with department heads to ensure that policies and procedures are followed.

3.3. Quality and Patient Safety Committee:

3.3.1. Quality planning on at least an annual basis as part of Hospital Strategic Planning process.

3.3.2. Ensure implementation of the Hospital wide Quality Improvement Plan.

3.3.3. Develop, implement and maintain a system for monitoring continued quality of patient care.

3.3.4. Support the performance improvement initiatives.

3.3.5. Review and approve or amend quality improvement procedures and systems for gathering, analyzing and using information under the Quality Improvement Program.

3.3.6. Review the effectiveness of the Quality Improvement Program and authorizes necessary resources and / or changes in organizational structure, systems and staff to improve program performance.

3.3.7. Assure that members are sufficiently educated in Quality Improvement Principles and methods to allow them to support and encourage necessary organizational change.

3.4. **Quality and Patient Safety Department:**

3.4.1. Assist the clinical and non-clinical staff and support systems in carrying out the Quality Improvement Program.

3.4.2. Monitor the activities of the Quality Improvement Program.

3.4.3. Maintain a register / database of policies, procedures and relevant information.

3.4.4. Generate Key Performance Indicators (KPI) reports to respective committees, departments and teams.

3.4.5. Serve as facilitators to Quality Improvement Teams.

3.4.6. Maintain Quality Improvement Education Plan.

3.4.7. Serve as support staff for the Hospital wide committees.

3.5. **Director of Quality Management and Patient Safety Department:**

3.5.1. Is responsible for the administration of Quality Improvement Program.

3.5.2. Run and supervise day to day affairs of Quality and Patient Safety Department and communicate to top management on the performance of quality and any need for improvement.

3.5.3. Represent Quality and Patient Safety Department within the Hospital and outside in MOH, CBAHI, JCI and others.

3.5.4. Provide leadership for development, implementation, communication and maintenance of Quality and Patient Safety Department policies and procedures.

3.5.5. Act as AMGH Accreditation Coordinator.

3.5.6. Establish the requirements of Quality and Patient Safety Department including policies and procedures and supervise the implementation of quality standards.

3.5.7. Participate in planning / implementation of Quality Improvement Plan, through education, establishment of committees and teams.

3.5.8. Demonstrate proper knowledge and implementation of Hospital and departmental policies and procedures.

3.5.9. Carry out consulting for quality within the Hospital and outside.

3.5.10. Assure the communication of results of the monitoring and evaluation process to the departments, relevant committees, teams or individuals.

3.5.11. Participate in Arabic / English educational activities within and outside the Hospital.
3.5.12. Coordinate the CBAHI accreditation process for the organization.
3.5.13. Communicate frequently to the department head and keeps him / her fully informed of any quality issue that is being addressed.
3.5.14. Support quality monitoring by being involved in data collection and reports this information to Quality and Patient Safety Department for analysis and actions.
3.5.15. Develop proposal and handles performance improvement projects.
3.5.16. Serves as an educator within his / her department through the use of simple continuous quality tools and problem solving methods

3.6. **Other Leadership**

3.6.1. **Medical Director**

3.6.1.1. Accountable for medical staff performance improvement, provides oversight / guidance for medical staff operations, delegate authority to the clinical department heads for monitoring, evaluating and ensuring timely action on quality improvement opportunities.
3.6.1.2. Ensure that findings, conclusions, recommendations and actions taken to improve organizational performance are communicated to appropriate medical staff members.
3.6.1.3. Take leadership roles in improving processes where the clinical process is the primary responsibility of physicians.
3.6.1.4. Ensure that the medical staffs participate in the measurement, assessment, and improvement of other patient care process such as patient and family education, accurate, timely, and legible completion of medical records.

3.6.2. **Risk Manager and Patient Safety coordinator**:

3.6.2.1. Work closely with Quality and Patient Safety Department to continuously improve the quality of healthcare, maintain a process of eliminating / mitigating risk and to assure compliance with regulatory standards related to Risk Management and Patient Safety.

3.6.3. **Director of Nursing Services**

3.6.3.1. Accountable for the nursing staff performance improvement, provides oversight / guidance for nursing staff operations, delegates authority to head nurses for monitoring, evaluating and ensuring timely action on nursing quality improvement opportunities.
3.6.3.2. Is accountable for establishing standards for ensuring the delivery of safe and quality nursing care and services.
3.6.3.3. Head nurses are responsible for the identification, prioritization of, and implementation of performance

improvement initiatives within and across their departments. Head nurses are accountable, responsible to evaluate, ensure clinical competency and provision of safe, quality care of all their nursing staff members.

3.6.4. **Department Heads**

3.6.4.1. The identification, prioritization, implementation of quality improvement activities, delivery of quality care services within their department, evaluation of its impact throughout the healthcare continuum to include multidisciplinary coordination of performance improvement efforts and reporting of results.

3.6.4.2. Responsible for the quality of care and service provided by their staff; to encourage staff participation in performance improvement initiatives; and for follow-up of actions related to quality improvement initiatives.

3.6.4.3. Ensure / monitor departmental compliance to **CBAHI** / **JCI** Standards.

3.6.4.4. Educate and empower staff in Quality Improvement Methodologies. Education is provided at time of orientation and at department meetings.

3.6.4.5. Assure quality improvement activities are carried out and appropriately documented.

3.6.4.6. Report a summary of departmental review activities, finding conclusions, recommendations, and actions implemented, follow-up to resolution and examples of actual performance improvement achieved.

3.6.5. **Other Committees (Safety Committee, Utilization Committee, Infection Control Committee, Pharmacy and Therapeutic Committee and other relevant committees)**

3.6.5.1. Communicate and collaborate with Quality and Patient Safety Department / Quality Improvement Committee concerning Quality Improvement activities.

3.6.5.2. Monitors the effectiveness of implemented corrective action plans.

3.6.6. **All Staffs:**

3.6.6.1. Learning the principles of quality improvement.

3.6.6.2. Reporting for any potential quality issues to their department head or supervisor, or directly to the Quality Improvement Department.

3.6.6.3. Carrying out the **FOCUS-PDCA** process to investigate and resolve improvement opportunities within teams.

3.6.6.4. Monitoring actions taken to assure continued resolution

4. POLICY:

4.1. The Quality Improvement Program involves with the accomplishment of Mission,
4.2. vision and values of hospital and quality department.
4.3. QIP deals with the achievement of goals and objectives of QI Plan.
4.4. Implementation of International Patient Safety Goals.
4.5. Priority setting criteria
4.6. Follow QI Methodology
4.7. Quality Improvement Teams
4.8. A team leader will be assigned to each Quality Improvement Team by the QM&PS Committee.
4.9. The team will be responsible for the following:
  4.9.1. Maintaining a current awareness of all external requirements regarding the function.
  4.9.2. Establishing a complete membership representative of all necessary departments or services, with approval of the appropriate Department Manager.
  4.9.3. Developing and revising the necessary policies and procedures for the function assigned.
  4.9.4. Establishing priority areas for the function assigned.
  4.9.5. Initiating performance improvement activities, as needed, for the function assigned.
  4.9.6. Determining educational needs of staff regarding all aspects of the function, and developing a plan for in-servicing, and implementing the educational activities
  4.9.7. Documenting all activities of the team, including a record of meeting minutes, performance improvement activities, performance improvement team composition, and Quality Management Team Goals.
  4.9.8. Developing performance improvement measures for areas established as priorities by the team members.
  4.9.9. Implementing actions necessary for improving performance.

5. PROCEDURE:

5.1. **Priority Setting Criteria**: In carrying out quality improvement initiatives in the hospital, departments and teams should prioritize improvement activities that meet one or more of the following criteria:
  5.1.1. Alignment with MOH and Hospital mission, vision, values and strategic goals.
  5.1.2. Meets the needs and expectations of internal and external customers.
  5.1.3. **High risk** diagnoses / procedures and other operational and bu8siness processes.

5.1.4. **High volume** diagnoses / procedures and other operational and business processes.
5.1.5. **High-cost** diagnoses / procedures and other operational and business processes.
5.1.6. **Problem prone** diagnoses / procedures and other operational and business processes.
5.1.7. Low Volume / **High Risk (sentinel events)**
5.1.8. Meets the regulatory and accreditation bodies' requirements.
5.1.9. Internal and External Customer Satisfaction need and on expectations

5.2. **Methodology:** The quality improvement methodology we will use is the FOCUS - PDCA:
5.2.1. **FIND** a process to improve.
5.2.2. **ORGANIZE** a team that knows the process.
5.2.3. **CLARIFY** current knowledge of the process.
5.2.4. **UNDERSTAND** causes of process variation.
5.2.5. **SELECT** the process improvement.
5.2.6. **PLAN** the improvement. Identify the opportunity for improvement; define your objective. Ask why are we doing this and how can we do it differently to make it better. Develop a multidisciplinary team; identify what you will measure.
5.2.7. **DO** the improvement process. Collect and analyze data. Implement your change strategies. Do small changes.
5.2.8. **CHECK/STUDY** the result. Understand the source of errors. Review the re - measurement data. Were the results of the change better, worse or a lateral change?
5.2.9. **ACT** to hold the gain and continue to improve the process. Follow up with documentation and report to the people involved

5.3. **Reporting:**

Report	Frequency of reporting	Participating / Issuing Department	Receiving Entity
Quality Management and Patient Safety Committee (QM&PSC) meeting minutes	Monthly	QM&PSC	Hospital Director
Departmental QI reports	Bi-annually	QM – Departmental QI teams	QM&PSC
Committee Reports	Annually	Respective committees	QM&PSC, Hospital Executive committee (HEC), Medical Executive committee (MEC)

Departmental Reports	Annually	Respective departments	Reporting authority
Mortality Reports	Monthly	Medical Records Department, Department Head	Mortality and Morbidity Committee
Occurrence Summary Reports	Quarterly	Quality Department	QM&PSC, Safety Committee, Pharmacy and Therapeutics Committee, Infection Control Committee, Specific departments concerned
QD meeting with Quality Directorate	Annually	Quality Department	Hospital Director

5.4. **Confidentiality**

5.4.1. Quality management information is considered confidential and may not be shared externally without permission from the Hospital Director.

5.5. **Annual Review**

5.5.1. The quality management plan is a three-year plan. It shall be reviewed and assessed for effectiveness annually at the end of every Gregorian year. The Hospital Executive committee shall be responsible for the review and the QD shall carry out communication of the updated plan. Department heads shall ensure communication of any changes and additions to the plan to their respective staff.

6. FORMS & EQUIPMENT:

6.1. Formulating an indicators form

7. APPROVAL

APPROVAL SIGNATURE SHEET				
	NAME	POSITION	SIGNATURE	DATE
Prepared By	Mr. Mohammad Sharahili	Quality and Patient Safety Coordinator		12/02/2025
Reviewed By	Dr. Yasir Agdi	Risk Manager,		15/02/2025
Reviewed By	Mr. Abdullah Hamami	LAB& B.B Director		17/02/2025
Reviewed By	Dr. Munif Ayashi	Pharmacy Director		17/02/2025
Reviewed By	Mr. Abdulrahman Al Amry	Nursing Services Director		18/02/2025
Reviewed By	Ms. Halima Saeed Babgi	Quality and Patient Safety Director		18/02/2025
	Dr. Hafiz Milhan	Medical Director		19/02/2025
Approved By	Mr. Falih bin Nasser Al Shahrani	General Executive Director Jazan Specialist Hospital		20/02/2025
Hospital Stamp	إدارة الجودة وسلامة المرضى Document الوثائق Quality & Patient Safety Department			